Part 2: Provider Information

Sections 2.1 – 2.4

Section 2.1: Approval Process

The Division of Disability and Rehabilitative Services (DDRS) will no longer be holding New Provider Orientation Sessions. Instead, a prospective provider shall submit a proposal during one of the quarterly open enrollment periods listed at http://www.in.gov/fssa/ddrs/2644.htm.

All components of the New Provider Proposal Packet (listed below) must be completed in order for an application to be considered. If any portion of the packet is incomplete, the proposal will be denied.

Proposals should be submitted to:
Director of Provider Relations
DDRS- Division of Disability and Rehabilitative Services
402 W. Washington St., RM 453, MS 18
Indianapolis, IN 46207
BDDSprovider@fssa.IN.gov

Bureau of Developmental Disabilities Services (BDDS) New Provider Proposal Packet

The packet consists of the six documents listed below. Open and print each of them to complete the packet. Reference material is also provided below.

- Application for Approval to Become a Provider of BDDS Services for Individuals with Developmental Disabilities
- Residential Services Documentation Requirements, Part 3
- Ancillary Services Documentation Requirements, Part 4
- FSSA Provider Data Form
- State of Indiana Automated Direct Deposit Authorization Agreement
- DDRS Provider Agreement

References

- Tool used for 460 Policy Development
- New Provider Orientation Slide Presentation 2011
- IAC 460 Rule 6
- Waiver Service Definitions/DD Renewal Appendix C
- Nurse Aide Registry
- Taxpayer Identification Request Form, W-9

Section 2.2: Requirements for all Providers

All Waiver Service providers must meet the following general requirements to gain approval and to remain in approved status:

- General administrative requirements for providers (460 IAC 6-10) include, but are not limited to, compliance with Medicaid and Medicaid Waivers, collaboration and quality control and quality assurance.
- Financial status for providers documenting financial stability and other fiscal issues. 460 IAC 6-11
- Insurance requirements for providers. 460 IAC 6-12
- Professional qualifications and requirements, including but not limited to, requirements for qualified personnel and training requirements. 460 IAC 6-14
- Personnel records requirements. 460 IAC 6-15
- Personnel policies and manuals requirements. 460 IAC 6-16
- Maintenance of records of services provided requirements. 460 IAC 6-17

Section 2.3: Provider Re-Approval

It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that approved providers must meet the specified requirements for re-approval in order to continue to offer services to individuals. The Division of Disability and Rehabilitative Services (DDRS) must have a signed Provider Agreement on file for all approved providers.

- DDRS will conduct a review of approved providers prior to the expiration of a provider's one (1) or three (3) year approval.

- DDRS will evaluate the following criteria for re-approval purposes:

    - CERT survey;
    - complaints investigations;
    - incident reports; and
    - any other information DDRS deems necessary.

- When DDRS issues a notice of re-approval, the provider will receive a letter indicating a term of one (1) or three (3) years with explicit instructions indicating that the re-approval is contingent upon the provider returning the signed Provider Agreement within thirty (30) days of receipt.

    - A provider will be required to return signed a Provider Agreement at least once every three years.

- If a provider fails to return a Provider Agreement within thirty (30) days, the provider has failed to meet the requirements for re-approval.

- If the provider fails to meet the requirements for re-approval, the provider will receive a letter indicating that the provider is under a six (6) month probationary approval and may be referred to the DDRS Sanctioning Committee.
    - During the six (6) month probationary period, the provider must show:
        - All incidents, sentinel events, and/or complaints open past the acceptable timeframes have been closed.
        - All systemic problems have been identified, addressed, and corrective action plans are in place and operational.
        - Compliance with the Sanctioning Committee's order(s).
            - If a provider fails to comply with any of the above requirements, the Sanctioning Committee may recommend that the Director terminate the provider's approval.

- All provider reviews under this policy may go before the DDRS Provider Review Committee for final re-approval decisions.

Administrative Review:

- To qualify for administrative review of a DDRS order, a provider shall file a written petition for review that does the following:
    - States facts demonstrating that the provider is:
        - a provider to whom the action is specifically directed;
        - aggrieved or adversely affected by the action; or
        - entitled to review under any law.
    - Is filed with the director of DDRS within fifteen (15) days after the provider receives notice of the sanctioning order.

- Administrative review shall be conducted in accordance with IC 4-21.5-3-7.

A provider adversely affected or aggrieved by BDDS' determination may request administrative review of the determination, in writing, within fifteen (15) days of receiving the notification. 460 IAC 6-6-5 (g)

If a provider has complied with the renewal timelines and if the BDDS does not act upon a provider's request for renewal of approved status before expiration of the provider's approved status, the provider will continue in approved status until such time as the BDDS acts upon the provider's request for renewal of approved services. 460 IAC 6-6-5 (f).

Section 2.4: Claims and Billing

Waiver Authorization

The waiver case manager is responsible for completing the Plan of Care/Cost Comparison Budget (CCB), which, upon approval by the State, results in an approved Notice of Action (NOA). The NOA details the services and number of units to be provided, the name of the authorized provider, and the approved billing code with the appropriate modifiers. The case manager transmits this information to the waiver database (INsite). INsite communicates this data to Indiana*AIM* where it is stored in the prior authorization database. Claims will deny if no authorization exists in the database or if a code other than the approved code is billed. Providers are not to render or bill services without an approved NOA. It is the provider's responsibility to contact the case manager in the event there is any discrepancy in the services authorized or rendered and the approved NOA.

Claim Tips and Reminders

When billing Medicaid waiver claims, the provider must consider the following:

- **The IHCP does not reimburse time spent by office staff billing claims.**
- Providers may only bill for those services authorized on an approved NOA.
- A claim may include dates of service within the same month. Do not submit a claim with dates that span across more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate Indiana Administrative Code (IAC) regulations and the waiver documentation standards issued by the OMPP and the Division of Disability and Rehabilitative Services (DDRS).
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.
- Updated information is disseminated through IHCP provider bulletins posted on indianamedicaid.com and/or the DDRS website at http://www.in.gov/fssa/2328.htm . Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.